U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 30Sep2002

CASE NO. 2001-BLA-01144

In the Matter of:
ZANE MOORE,
Claimant

v.

ELKAY MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Mary Jane Merritt, Lay Representative
For the Claimant

Mary Rich Maloy, Esq.
For the Employer

BEFORE: ROBERT J. LESNICK
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a claim for benefits under 30 U.S.C. §§ 901-945. In accordance with the Act and regulations issued thereunder, this case was referred to the office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awardable to persons who are totally disabled within the meaning of the Act due to pneumoconiosis. Benefits are also awardable to the survivors of persons whose death was caused by pneumoconiosis, and for claims filed prior to January 1, 1982, to the survivors of persons who were totally disabled from pneumoconiosis at the time of the deaths. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment. It is commonly known as black lung.

Claimant requested a hearing before this Office on May 8, 2001 (DX 86) following the denial on April 26, 2001 by the Director, Office of Workers' Compensation Programs (OWCP) of Claimant's December 11, 2000 request for modification of the denial of benefits on this claim (DX 83, 75).

A formal hearing was held in Charleston, West Virginia on June 11, 2002 at which time all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20, Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to the sections of that Title. At the hearing, Claimant appeared without counsel, but his daughter, Mary Jane Merritt, acted as a lay representative. Claimant requested that this matter proceed since he had not be able to obtain legal representation for his case (TR. 6).

At the hearing, Director's Exhibit 1 through 91 (DX) , Claimant's Exhibits 1 and 2 (CX) , Employer's Exhibits 1 through 12, and 14 (EX) and Administrative Law Judge's Exhibit 1 (ALJX) were admitted into evidence. The parties agreed for Employer to submit some evidence post-hearing, including an additional portion of the deposition of Dr. G. Zaldivar which would allow Claimant the opportunity to cross-examine Dr. Zaldivar, as well as readings of the most recent CT scans. Dr. Zaldivar's initial deposition testimony, taken on May 28, 2002, is admitted as Employer's Exhibit 13, and the cross-examination deposition testimony, taken on July 8, 2002, is admitted as Employer's Exhibit 15. In addition, Dr. P. Wheeler's readings of the CT scans of July 9, 2001 and April 4, 2002 are admitted as Employer's Exhibit 16 and Dr. W. Scott's readings of the July 9, 2001 and April 4, 2002 CT scans are admitted as Employer's Exhibit 17.

ISSUES

I. Has there been a change in Claimant's physical condition?

II. Was a mistake in fact made in the prior denial as affirmed by the Benefits Review Board?

III. Does Claimant have pneumoconiosis?

IV. Does Claimant's pneumoconiosis arise out of coal mine employment?

V. Is Claimant totally disabled?

VI. Is Claimant's total disability due to pneumoconiosis?

No appearance was entered on behalf of the Director, Office of Workers' Compensation Programs.

Procedural History

Claimant filed two different claims for benefits. His first claim, filed on June 28, 1973, was finally denied by OWCP on August 13, 1980 since the evidence showed Claimant was still working at that time (DX 30). On June 16, 1994, Claimant filed a second claim for benefits. In a Proposed Decision and Order issued on February 9, 1996, the District Director found Claimant had established thirty-three years of coal mine employment, and that he had one dependent, his wife, for purposes of benefits augmentation. The District Director also found Claimant had established the presence of pneumoconiosis by the chest x-ray evidence of record. Benefits were denied, however, since Claimant had not established total disability due to such pneumoconiosis (DX 26).

Claimant requested a hearing and a hearing was held before Administrative S. Levin. In a brief submitted following the hearing, Employer stated, "although the evidence is sufficient to establish Claimant has pneumoconiosis..." (DX 61), conceding that Claimant had established the presence of pneumoconiosis. In his Decision and Order of February 16, 1999, however, Judge Levin included no findings on the presence or absence of pneumoconiosis, but rather found the evidence failed to establish total disability under any of the provisions of Section 718.204(c) [now found at 20 C.F.R. 718.204(b)(2)]. Since Judge Levin found total disability was not established, he denied the claim for benefits (DX 62).

Claimant appealed to the Benefits Review Board (Board), which affirmed the denial of benefits on March 9, 2000 (DX 69). The Board found the administrative law judge correctly determined the pulmonary function study results and blood gas study results were non-qualifying and, therefore, the Board affirmed Judge Levin's finding that total disability was not established under subsection 718.204(c)(1) or (c)(2) [now 20 C.F.R. 718.204(b)(2)(i) and (b)(2)(ii)]. In addition, the Board found that Judge Levin correctly determined there was no evidence of cor pulmonale and his finding that total disability was not established under subsection 718.204(c)(3) [now subsection 718.204(b)(2)(iii)] was affirmed. Finally, the Board found Judge Levin's conclusion that the medical evidence was not sufficient to establish total disability under subsection 718.204(c)(4) [now subsection 718.204(b)(2)(iv)] was supported by his finding that no physician concluded Claimant was totally disabled by his respiratory or pulmonary impairment. Dr. Rasmussen's finding that Claimant was unable to perform heavy labor was not sufficient since the evidence did not establish Claimant's last coal mine employment required continuous heavy labor, and even if Dr. Rasmussen's opinion was sufficient, it was outweighed by the contrary better-reasoned and better-supported reports of Drs. Zaldivar, Castle, Piracha, Ranavaya, Crisalli, and Fino. In footnotes, the Board noted Judge Levin's error in not addressing the presence of pneumoconiosis was harmless since he properly found Claimant had not established total disability due to pneumoconiosis. Accordingly, the Board affirmed the denial of benefits.

On March 16, 2000, Claimant submitted a letter to the Board which was treated as a motion for reconsideration (DX 70). On June 22, 2000, the Board denied the motion for reconsideration (DX 71).

Claimant then submitted new evidence and requested modification on December 11, 2000 (DX 75). This request was denied by the District Director, OWCP on April 26, 2001 (DX 83). The District Director noted the previous finding of the presence of pneumoconiosis that arose out of coal mine employment. The District Director also noted Claimant's pulmonary condition had deteriorated. However, the District Director concluded the cause of the impairment had not been established and, therefore, the request for modification was denied (DX 83). As noted above, Claimant requested a hearing and this matter was referred to the Office of Administrative Law Judges on August 8, 2001 (DX 86, 88). A hearing was held on June 11, 2002.

Modification

Claimant's request for modification is governed by Section 725.310 of the regulations which provides that any party may request modification of the denial of a claim if such request is filed within one year of the denial. Under Section 725.310(a), the terms of the award or denial of benefits can be reconsidered if the party asking for modification can establish a change in conditions or mistake in a determination of fact.

Where a mistake of fact forms the grounds for the modification request, new evidence is not a prerequisite, and mistake of fact may be corrected whether demonstrated by new evidence, cumulative evidence or further reflection on evidence initially submitted. § 725.310(c); *Kovac v. BCNR Mining Corporation,* 16 BLR 1071 (1992), *modifying* 14 BLR 1-156 (1990).

Change in condition as an alternate ground for modification focuses on whether there has been a worsening of the miner's pulmonary disease to the point that it is now totally disabling. In determining whether the miner has established a change in condition, the administrative law judge must conduct an independent assessment of the newly submitted evidence, in conjunction with the evidence previously submitted to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement in the prior decision. *Napier v. Director, OWCP*, 17 BLR 1-111 (1993).

Medical Evidence

Chest X-ray Reports

EX. NO.	DOCTOR	CRDNTL	DATE OF X-RAY	DATE OF READING	FILM QUAL	READING (ILO-U/C)
DX 30	Finck		03-13-79	06-06-79	1/1 q	
DX 30	Subramaniam		03-13-79	03-14-79	1/1 t	
DX 30	Pathak		01-17-80	01-22-80	1/1 p	

EX. NO.	DOCTOR	CRDNTL	DATE OF X-RAY	DATE OF READING	FILM QUAL	READING (ILO-U/C)
DX 14	Ranavaya		07-28-94	09-29-94	1/1 q, p	
DX 13	Franke	B, BCR[1]	07-28-94	09-29-94	1/1 q, p	
DX 35	Zaldivar	B	07-28-94	08-28-95	1/1 q, q	
DX 25	Scott	B, BCR	07-28-94	11-07-95	negative	
DX 35	Wheeler	B, BCR	07-28-94	11-07-95	1/1 q, q	
DX 35	Kim	B, BCR	07-28-94	11-28-95	1/0 q, q	
DX 19, 50	Rubenstein		03-16-95		possible pneumoconiosis	
DX 35	Wheeler	B, BCR	03-16-95	11-07-95	1/1 q, q	
DX 35	Scott	B, BCR	03-16-95	11-07-95	1/1 t, q	
DX 35	Kim	B, BCR	03-16-95	11-28-95	1/0 q, q	
EX 10	Castle	B	03-16-95	04-19-02	1/1 q, t	
EX 11	Pendergrass	B, BCR	03-16-95	04-27-02	1/1 q, t	
DX 50	Roth		06-15-96		Chronic interstitial pulmonary nodularities without evidence of active parenchymal disease	
DX 27	Leef		11-24-95	12-04-95	1/1 q, t	
DX 35	Wheeler	B, BCR	11-24-95	12-21-95	1/0 q, q	
DX 35	Scott	B, BCR	11-24-95	12-21-95	1/0 t, q	
DX 35	Kim	B, BCR	11-24-95	01-12-96	1/0 p, t	
EX 10	Castle	B	11-24-95	04-19-02	1/1 q, t	
EX 11	Pendergrass	B, BCR	11-24-95	04-27-02	1/1 q, t	
DX 79	Bassali	B, BCR	04-03-96	04-08-96	2/2 q, r	
DX 51	Zaldivar	B	05-07-97	05-18-97	1/1 r, r	

[1] The symbol "B" denotes a physicians who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a radiologist who has demonstrated his expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. §37.51 (1982).

The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(III).

EX. NO.	DOCTOR	CRDNTL	DATE OF X-RAY	DATE OF READING	FILM QUAL	READING (ILO-U/C)
DX 85	Wheeler	B, BCR	08-07-00	04-21-01	No pneumoconiosis, mass	
EX 10	Castle	B	08-07-00	04-19-02	1/2 q, t, mass	
EX 11	Pendergrass	B, BCR	08-07-00	04-27-02	1/2 q, u, large opacity	
EX 13	Zaldivar	B	08-07-00	05-28-02	1/ w, r, mass	
DX 39	Dwyer		09-18-00	09-18-00	large mass, RUL	
DX 82	Zaldivar	B	03-07-01	04-03-01	1/1 q, q, mass	
DX 87	Wiot	B, BCR	03-07-01	04-24-01	no pneumoconiosis, mass	
DX 88	Spitz	B, BCR	03-07-01	05-03-01	no pneumoconiosis, mass	
EX 1	Wheeler	B, BCR	03-07-01	07-03-01	no pneumoconiosis, mass	
EX 1	Scott	B, BCR	03-07-01	07-03-01	no pneumoconiosis, mass	
EX 1	Kim	B, BCR	03-07-01	07-14-01	no pneumoconiosis, mass	
EX 10	Castle	B	03-07-01	04-19-02	1/2 q, t, mass	
EX 11	Pendergrass	B, BCR	03-07-01	04-27-02	1/2, q, u, mass	

Pulmonary Function Test Results:

The record includes several non-qualifying pulmonary function studies taken prior to the denial of this claim in February, 1999. The record also includes the following newly submitted pulmonary function study results:

EX. NO.	PHYSICIAN	DATE	AGE	HGT	FEV_1	FVC	FEV_1 FVC	MVV	COOP
DX 79	D'Brot	10-11-00	66	67"	1.69	2.46	69%	---	Good
DX 82	Zaldivar	03-07-01	67	66"	1.80	2.98	60%	69	Good
					1.84	2.94	63%	71	Good

Arterial Blood Gas Studies

Likewise the record includes several non-qualifying blood gas studies which were considered by Administrative Law Judge Levin in his denial of February, 1999. The record includes the following newly submitted blood gas study results:

EX NO.	DATE	DOCTOR	pCO_2	pO_2	AT REST/ AFTER EXERCISE
DX 79	10-11-00	D'Brot	33	85	At rest
			35	83	After exercise
DX 82	03-07-01	Zaldivar	37	87	At rest
			85	73	After exercise

CT Scans

Several CT scans have been taken since the mass was discovered in Claimant's right lung.

Exhibit	Date	Date Read	Physician	Reading
DX 85	8-11-00	04-21-01	Wheeler	Mass, RML*, no pneumoconiosis
DX 85	8-11-00	04-24-01	Scott	Mass, RML, no pneumoconiosis
EX 3	8-11-00	11-08-01	Wiot	Mass, RML, no pneumoconiosis
EX 7	8-11-00	11-24-01	Spitz	Mass, RML, no pneumoconiosis
EX 9	8-11-00	12-26-01	Meyer	Limited chest CT scan due to thick sections sections, scattered apical centrilobular nodular opacities consistent with coal workers' pneumoconiosis, 2) RML mass
EX 15	8-11-00	05-28-02	Zaldivar	Simple coal workers' pneumoconiosis, mass, RML
EX 16	07-09-01	06-24-02	Wheeler	Mass
EX 17	07-09-01	06-26-02	Scott	Mass, RLL, no pneumoconiosis
EX 16	04-04-02	06-19-02	Wheeler	Mass, no pneumoconiosis
EX 18	04-04-02	06-26-02	Scott	Mass, no pneumoconiosis

*Right lung, mid-lobe

Medical Opinions

The record includes the medical reports discussed by Judge Levin and that discussion is incorporated by reference herein (DX 62). In addition, Claimant has submitted extensive medical records, including statements from Dr. J. D'Brot, his treating physician and a pulmonary specialist.

In a report dated September 7, 2000, Dr. D'Brot stated this was his first examination of Claimant. Claimant had been referred to Dr. D'Brot, a pulmonary specialist, based on an abnormal chest x-ray. Dr. D'Brot reported Claimant's lungs were clear to auscultation and percussion. He concluded Claimant had coal workers' pneumoconiosis, an abnormal chest x-ray with a right mid-lung mass which could be progressive fibrosis or neoplasia, and obstructive sleep apnea by history. Dr. D'Brot stated in this report he would proceed with various tests; however, he stated it was his opinion the mass looked more like coal workers' pneumoconiosis (DX 79). On October 18, 2000, he again stated Claimant had a possible progressive pulmonary fibrosis or neoplasm, as well as a cough secondary to the bronchoscopy procedure (DX 79). On October 19, 2000, Dr. D'Brot noted an abnormal PET scan but coal workers' pneumoconiosis present on biopsies (DX 79).

In a letter dated November 21, 2000, Dr. D'Brot stated Claimant has an abnormal chest x-ray with biapical masses and that a transbronchial biopsy showed anthracosis (coal workers' pneumoconiosis) present. Dr. D'Brot stated Claimant's respiratory status has declined and he is disabled. He noted that cardiopulmonary tests showed significant ventilatory impairment with exercise with normal cardiac vascular function during exercise. In addition, he stated pulmonary function tests showed restrictive lung disease, 40% impairment (DX 79).

In a report dated November 13, 2001, Dr. D'Brot stated anthracosis was present in both biopsies in a lumpectomy. Based on Claimant's long history of coal mine employment, as well as the findings in both biopsies, Dr. D'Brot diagnosed coal workers' pneumoconiosis (CX 1-1, 1-52). In an office visit report dated May 16, 2002, Dr. D'Brot stated Claimant's lungs were clear on physical examination and the mass was unchanged on CT scan. Since the mass had been stable in size for two years, Dr. D'Brot stated he doubted the mass was carcinoma. He noted the mediastinoscopy showed coal workers' pneumoconiosis was present in the mediastinal nodes. Putting all the information together, Dr. D'Brot stated that it is his opinion Claimant has pulmonary fibrosis related to his exposure to coal dust (CX 1-117).

Following the biopsy on September 12, 2000, Dr. M. Plata stated in his surgical pathology report the procedure produced fragments of bronchial wall and lung parenchyma which showed moderate anthracosis. There was no evidence of granuloma or malignancy. Dr. Plata's post-operative diagnosis was anthracosis (DX 79). The cytology fine needle aspiration report dated September 13, 2000 by Dr. Hansen stated there was marked cytolysis or autolysis and macrophage with pigment present (DX 79). Following the mediastinoscopy on October 13, 2000, Dr. Chalid reported there was no evidence of malignancy but there was evidence of granuloma (DX 79). In an addendum dated October 16, 2000, Dr. Mellen, a pathologist, reported: 1) right paratracheal lymph node biopsy with mild anthracosis, 2) subcarinal lymph node biopsy with granulomas and anthracosis (DX 79).

On April 4, 2001, Dr. G. Zaldivar, a pulmonary specialist, performed physical examination and reviewed the medical records. Dr. Zaldivar noted he had performed an earlier examination on May 21, 1997. He noted the mass was discovered in August, 2000 and that the treating physician had concluded the mass was black lung. On physical examination, Dr. Zaldivar reported lungs clear to auscultation without wheezes, crackles, or rales. His impression on examination was: 1) mass newly developed since the prior examination in 1997, 2) history of shortness of breath, 3) hoarseness of recent onset, and 4) history of wheezing. Following his examination, review of laboratory test results

and review of Claimant's medical records, Dr. Zaldivar concluded Claimant has a mild restriction of his forced vital capacity and total lung capacity and a mild irreversible airway obstruction. In addition, Claimant has a mild diffusion impairment with deterioration in results from May, 1997. Claimant has the low carboxyhemoglobin values of a current non-smoker. Dr. Zaldivar stated Claimant has simple coal workers' pneumoconiosis and a mass or lesion which, in his opinion, is cancer. In addition, he stated Claimant has moderate exercise limitation due to the ventilatory limitations with a mild drop in oxygen during exercise. Dr. Zaldivar stated further that the positive uptake by PET scanning is more compatible with malignancy than an inflammatory lesion, the biopsy results were inconclusive and the chest x-ray is not consistent with a finding of progressive massive fibrosis which is usually in the upper zones. Claimant has deteriorated in his ventilatory capacity and exercise capacity, however, radiographically the only change is the development of the mass. Dr. Zaldivar concluded, therefore, there is sufficient objective evidence to justify a diagnosis of simple coal workers' pneumoconiosis which arose from coal mine employment, Claimant's pulmonary impairment has progressed since 1997, however, his pulmonary impairment is not sufficient to prevent him from performing his usual coal mine employment, and his pulmonary impairment is a result of cancer of the lungs. Dr. Zaldivar noted the deterioration of his pulmonary condition due to cancer could be confirmed by following the results over a one year period (DX 82).

At a deposition taken on May 28, 2002 and July 8, 2002, Dr. Zaldivar explained some of the reasons why he concluded the mass which has developed is due to cancer or some other cause than pneumoconiosis. Dr. Zaldivar stated the development of the hoarseness was one concern. In addition, the location of the mass is not consistent with coal workers' pneumoconiosis. He stated this would be the first case in medical literature of complicated pneumoconiosis in the mid lobe of a miner's lung. Dr. Zaldivar also explained why the biopsies, although negative for cancer, should not be relied upon as establishing cancer is not present since these types of biopsies give only minimal information. Dr. Zaldivar stated he would recommend excisional or surgical biopsy to gather more information about the mass. Dr. Zaldivar also stated the improvement on lung function testing from Dr. D'Brot's tests in September, 2000 to his tests in March, 2001 shows the changes are not permanent, but variable. Dr. Zaldivar agreed Claimant has had a deterioration in his lung function since 1997 which he attributed to Claimant's aging process and to some bronchospasm. Dr. Zaldivar discussed Claimant's work as a buggy operator which required sporadic heavy labor. He stated Claimant would be capable of doing such work, but he would not be capable of sustained or continuous heavy labor. Dr. Zaldivar stated it was his opinion the cause of Claimant's mild pulmonary impairment is a combination of the coal workers' pneumoconiosis present, a bronchospasm and the presence of the mass. Dr. Zaldivar also stated the CT scans are not good tools for monitoring the growth since they take pictures of slices of the miner's lungs and would take different slices on each scan. Finally, he explained that the fact the mass has not grown in a one year period, as noted in his written report, does not rule out cancer as the cause since cancer can grow slowly or fast (EX 13, 15).

Dr. J. Castle, a pulmonary specialist, reviewed the medical evidence on December 10, 2001. Dr. Castle stated there is radiographic evidence of simple coal workers' pneumoconiosis. He noted the development of a large mass in the right mid-lobe which was undiagnosed as to the etiology. He noted

the mass has radiographic and CT scan characteristics of a malignancy and he noted the PET scan, a test which is sensitive for malignancies, was positive. Dr. Castle stated Claimant has had some deterioration in his overall ventilatory function since the mass developed; however, his physiologic function remains above the disability levels. Dr. Castle concluded the mass is a malignancy and Claimant is not totally disabled from coal mine employment since he continues to demonstrate physiologic function sufficient to perform his last coal mine employment (EX 4). At a deposition taken on June 4, 2002, Dr. Castle again noted the presence of simple coal workers' pneumoconiosis on chest x-ray. He discussed the basis for his conclusion that the mass is not related to complicated pneumoconiosis, including the location of the mass which is not typical for coal workers' pneumoconiosis, the time frame for when the mass developed which is not typical for coal workers' pneumoconiosis and the other characteristics of carcinoma present, including the positive PET scan. Dr. Castle also explained the biopsy procedure which takes blind samples from an area where the mass is located. Since these samples are taken blind, however, the fact that the sample is negative does not mean cancer is not present. The mediastinoscopy, the second "biopsy" test, sampled the lymph nodes which drain foreign material, including tumor material, from the chest. This test showed a type of granuloma and inflammation, but it did not show evidence of cancer. Dr. Castle felt, however, more aggressive attempts to diagnose the source of the mass would be advisable. Dr. Castle reiterated his conclusions regarding Claimant's pulmonary capacity and the etiology of the changes present (EX 4).

Dr. G. Fino, also a pulmonary specialist, reviewed the evidence on December 5, 2001. Dr. Fino noted in prior reports, dated April 16, 1996, September 16, 1996 and April 1, 1998, he had concluded Claimant has simple coal workers' pneumoconiosis with no pulmonary disability related to his lung diagnoses. After reviewing additional evidence, Dr. Fino stated Claimant has had a change in lung function from 1997 to 2001 with a slight drop in the FEV-1, a drop in oxygen transfer on exercise, and a decrease in lung volumes which suggests an obstructive and restrictive abnormality. Dr. Fino noted the development of a 2 x 2 inch lung mass in the mid or lower lobe of Claimant's right lung. He stated the location is not consistent with complicated coal workers' pneumoconiosis and he noted the PET scan was positive which is a test that is quite specific and sensitive for malignancy. Dr. Fino concluded it was his opinion the malignancy is causing the overall respiratory status changes. He concluded Claimant has coal workers' pneumoconiosis but no disability due to coal workers' pneumoconiosis. The change in Claimant's pulmonary status is related to the development of the malignancy and not to complicated coal workers' pneumoconiosis (EX 4).

On December 11, 2001, Dr. D. Rosenberg, a pulmonary specialist, reviewed the medical evidence. Dr. Rosenberg noted initial chest x-ray readings were all positive for coal workers' pneumoconiosis, but some of the more recent chest x-ray readings and CT scans have been negative for coal workers' pneumoconiosis. He reported Claimant's diffusing capacity is normal and recently his oxygen transfer had dropped slightly, but not to a limiting degree. Based on the recent negative readings, Dr. Rosenberg concluded Claimant does not have simple coal workers' pneumoconiosis. The mild restriction and mild obstruction present on testing is minimal and not limiting. The restrictive problems present are probably due to the development of the mass in his lung and the obstructive problems present are probably due to his prior coal mine employment. Dr. Rosenberg stated it was his opinion the mass is a malignancy; however, he also stated the mass has not been appropriately biopsied.

Dr. Rosenberg concluded there is no change in Claimant's pulmonary capacity even if coal workers' pneumoconiosis is present (EX 5).

On December 19, 2001, Dr. Crisalli prepared an additional report after reviewing additional medical records. His initial report was considered in the proceedings before Judge Levin. In that report, Dr. Crisalli concluded Claimant has coal workers' pneumoconiosis but with only a mild pulmonary impairment which would not prevent him from performing his ususal coal mine employment (DX 27). In the new report, Dr. Crisalli again concluded there is sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis. In addition, he stated there is now a significant respiratory impairment present based on the last study performed by Dr. Zaldivar. Dr. Crisalli stated, however, it is his opinion these changes are related to a pathologic process other than coal workers' pneumoconiosis. Dr. Crisalli stated Claimant is totally disabled based on the most recent blood gas study results. He noted, however, there is no evidence of complicated pneumoconiosis nor is there evidence of worsening of Claimant's simple coal workers' pneumoconiosis. Rather, he stated the deterioration of Claimant's pulmonary function correlates to the development of the mass which is not related to coal mine employment nor coal workers' pneumoconiosis (EX 6).

Finally, the record includes reports from three physicians who reviewed the material from the biopsies. On November 22, 2001, Dr. R. Naeye, a board-certified pathologist, reviewed the tissue from the transbronchial biopsy of November, 2000, material from the second biopsy of the lymph nodes and Claimant's medical records. Dr. Naeye concluded Claimant has an expanding mass, which is thought to be a neoplasm. He also noted the material from the first surgical biopsy contained no tissue from the mass. He noted the material from the second biopsy of the lymph nodes suggested an infectious process. He stated the material did not show changes of coal workers' pneumoconiosis. Based on the absence of coal workers' pneumoconiosis on this biopsy sample, as well as the negative chest x-ray readings, Dr. Naeye concluded there is no convincing evidence of coal workers' pneumoconiosis severe enough to significantly affect Claimant's lung function and cause his disability (EX 2).

Dr. S. Bush, a board-certified pathologist, reviewed the evidence and histologic slides on January 4, 2002. He noted there is no histologic evidence of coal workers' pneumoconiosis on the slides although he stated the slides from the second biopsy showed mild anthracosis. Dr. Bush stated the slides showed an extremely small amount of lung tissue and were not representative of Claimant's lungs. Therefore, he stated it was his opinion the presence or absence of pneumoconiosis should be based on the clinical and radiographic information and, based on that information, it was his opinion coal workers' pneumoconiosis is present but it is extemely limited in degree and extent. Dr. Bush stated Claimant has a mild degree of respiratory impairment based on the pulmonary function studies; however, he is totally disabled by his obesity, deconditioning, osteoarthritis and probably cancer of the lung. The coal workers' pneumoconiosis present does not contribute to his respiratory impairment or disability (EX 8).

Similarly, Dr. E. Oesterling, also board-certified in pathology, reviewed the records and lung slides on May 2, 2002. Dr. Oesterling stated the samples from the biopsies showed the presence of mine dust, but only in relatively modest quantities. There was no evidence of disease process on these slides. Dr. Oesterling concluded, based on the histologic material available, it is not feasible to

diagnose the disease process of coal workers' pneumoconiosis. Dr. Oesterling added, however, the choice of biopsy specimens is unfortunate since they do not allow the opportunity to confirm the miner's disease process (EX 12).

Issues

In the prior denial of February 16, 1999 (DX 62), Judge Levin denied the claim for benefits because Claimant failed to establish total disability due to pneumoconiosis. Although the Employer had conceded the presence of pneumoconiosis, Judge Levin made no specific findings on that issue. In this proceeding on modification, therefore, the presence of pneumoconiosis that arose out of coal mine employment, as well as whether Claimant is totally disabled due to such pneumoconiosis shall be addressed.

Discussion

Entitlement to benefits depends upon proof of three elements. In general, a miner must establish that: 1) he has pneumoconiosis which, 2) arose out of coal mine employment, and which 3) is totally disabling. Failure to prove any of these requisite elements precludes a finding of entitlement. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986).

Pursuant to Section 718.202, a living miner can demonstrate the presence of pneumoconiosis by: 1) x-rays interpreted as being positive for the disease; or 2) biopsy evidence; or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable; or 4) a reasoned medical opinion which concluded the disease is present, if the opinion is based on objective medical evidence such as blood-gas studies, pulmonary function studies, physical examinations, and medical and work histories.

The chest x-ray readings include two negative readings and twenty-seven positive readings for pneumoconiosis through May, 1997. The recent readings include three positive readings and one negative reading for a film taken in August, 2000 and three positive readings and five negative readings for a film taken in March, 2001. Three of the negative readings of the recent x-ray films were made by Drs. Scott, Williams and Kim, who had earlier read several x-ray films as positive for pneumoconiosis. These physicians, however, provided no explanation for the change in their readings. I accord less weight to this one negative reading by Drs. Scott, Williams and Kim, in light of their contradiction, without explanation, of their own earlier multiple positive readings. The two additional negative x-ray readings were by Drs. Wiot and Spitz. This film was the only film these physicians read. Other physicians of record, however, read x-ray films over several years and consistently found pneumoconiosis was present on the chest x-ray films. Under such circumstances, I find the long history of many positive x-ray readings by highly qualified physicians outweighs the negative readings submitted on the recent two x-ray films by Drs. Wiot and Spitz. Accordingly, I find that Claimant has established pneumoconiosis by the chest x-ray evidence of record under §718.202(a)(1).

Claimant has not established pneumoconiosis under §718.202(a)(2) by the biopsy evidence of record. Although some of the biopsy reports include a finding of anthracosis or pigmentation, I find most persuasive the reports of the physicians who stated the lung tissue present was too small to assess the presence or absence of pneumoconiosis. Thus, I find the biopsy specimens did not establish pneumoconiosis nor did they establish the absence of pneumoconiosis. Pneumoconiosis is not, therefore, established under the provisions of subsection 718.202(a)(2). Likewise, pneumoconiosis is not established under §718.202(a)(3) since none of the presumptions are applicable to this claim.

The final way to establish the existence of pneumoconiosis under Section 718.202(a) is set forth in subparagraph (a)(4). A determination of the existence of pneumoconiosis may be made, notwithstanding a negative x-ray, if a physician exercising sound medical judgement finds the miner suffers from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence, such as arterial blood gas tests, physical performance tests, physical examinations, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion. Most of the extensive medical reports included in the record, both those submitted prior to Judge Levin's findings on February 16, 1999, and those submitted subsequent to Claimant's request for modification, conclude that simple coal workers' pneumoconiosis is present. This includes the reports (often multiple reports) of Drs. D'Brot, Zaldivar, Castle, Fino and Crisalli. The only contrary report is the report of Dr. Rosenberg who only prepared one report in this matter. I find the reports by the physicians who examined Claimant on more than one occasion and examined the medical records over several times over several years to be more persuasive. Therefore, I find the weight of the medical opinion evidence establishes the presence of pneumoconiosis under the provisions of subsection 718.202(a)(4).

Arose out of Coal Mine Employment

In addition to establishing the presence of pneumoconiosis, a claimant must also establish that such pneumoconiosis arose out of his coal mine employment. The rebuttable presumption that such pneumoconiosis arose out of Claimant's coal mine employment at subsection 718.203(b) is applicable since Claimant has established twenty-eight years of coal mine employment. In addition, all the physicians who diagnosed pneumoconiosis agreed that Claimant's pneumoconiosis arose out of his coal mine employment. Accordingly, I find Claimant has not established that pneumoconiosis arose out of his coal mine employment.

The failure of Judge Levin to make any findings on the issue of the presence of pneumoconiosis which arose out of pneumoconiosis was found to be harmless error by the Benefits Review Board. It is not clear, however, if this harmless error constitutes a mistake in fact which requires modification of the denial of benefits. For purposes of this determination, I find Claimant has established by a strong preponderance of the evidence the presence of simple coal workers' pneumoconiosis which arose out of coal mine employment. This finding is based on both the evidence submitted prior to the denial of February, 1999 and the evidence submitted subsequent to Claimant's request for modification.

Assuming this finding, that pneumoconiosis has been established, requires modification of the denial of benefits, the evidence of record must then be considered on the merits. For reasons set forth above, I find that pneumoconiosis which arose out of coal mine employment has been established. Claimant must still establish total disability due to such pneumoconiosis to establish entitlement to benefits in this matter.

Total Disability Due to Pneumoconiosis

The determination of total disability shall be made under the provisions of Section 718.204. Initially, I note that Dr. D'Brot, Claimant's treating physician, attributed the recent development of a lung mass to progressive fibrosis due to pneumoconiosis. This opinion was contradicted by the reports of Drs. Zaldivar, Castle, Fino and Crisalli. These physicians gave several reasons for their conclusions that the mass was not related to coal workers' pneumoconiosis. Specifically, they discussed the location of the mass which is not consistent with complicated pneumoconiosis or progressive fibrosis due to pneumoconiosis. Dr. Zaldivar even stated that if this mass in the mid lobe of the right lung were found to be complicated pneumoconiosis, it would be the first recorded time in medical history that complicated pneumoconiosis was found in that location. Rather, complicated pneumoconiosis is found in the upper lobes while masses developing in the mid or lower lungs are due to other causes.

In addition, several physicians noted that the PET scan was positive for a malignancy and that this test is very sensitive to the presence of a malignancy. Finally, these physicians also noted that the results of the biopsies were not helpful in assessing the etiology of the mass, but they did not out-rule malignancy or cancer as a possible cause. After considering these medical reports, I find Dr. D'Brot's opinion is outweighed by the more thorough discussion by Drs. Zaldivar, Castle, Fino and Crisalli as to the etiology of the lung mass which all physicians agree is present. Thus, I find the probative weight of the evidence does not establish the presence of complicated pneumoconiosis and, thus, I find Claimant has not invoked the irrebuttable presumption of total disability set forth at Section 718.204(b)(1). A claimant, however, may also establish total disability under the provisions of subsection 718.204(b)(2) if relevant probative evidence meets one of the four standards set forth at that subsection.

The pulmonary function study reports of record are set forth above. Claimant did not demonstrate qualifying values on any of these studies, either those considered in the prior denials or the newly submitted pulmonary function studies. On the more recent studies, Claimant demonstrated a qualifying value on the FEV-1 portion of the October, 2000 pulmonary function study, but neither the FVC value nor the FEV-1/FVC ratio was qualifying. In addition, Claimant did not demonstrate qualifying values on any portion of the more recent March, 2001 pulmonary function study either on room air or after the use of bronchodilators. The newly submitted values, therefore, which are non-qualifying outweigh the one positive value and do not establish total disability under subsection 718.204(b)(2)(i) nor do they establish a change in conditions since the prior denial.

None of the newly conducted blood gas studies demonstrated qualifying values. Several physicians noted that Claimant demonstrated a deterioration on the most recent blood gas study results taken after exercise. These physicians, however, also noted the values were still non-qualifying under

the regulations. Accordingly, total disability is not established under subsection 718.204(b)(2)(ii). Since there is no evidence of cor pulmonale, total disability is not established under subsection 718.204(b)(2)(iii). Furthermore, there is no basis for a finding of change in conditions or mistake in fact on consideration of the newly submitted evidence with the evidence considered in the prior denial under these two subsections.

The other means of establishing total disability under §718.204(b)(2) is by a reasoned medical opinion which concludes the miner is totally disabled, if the opinion is based on medically acceptable clinical and laboratory diagnostic techniques. The medical reports are set forth above and their findings on Claimant's pulmonary capacity are summarized below. Dr. D'Brot, Claimant's treating physician, concluded, based on cardiopulmonary tests of October, 2000, Claimant's respiratory status has declined. Dr. Zaldivar concluded Claimant's ventilatory capacity and exercise capacity have deteriorated; however, he also stated Claimant's pulmonary impairment is not sufficient to prevent him from performing his usual coal mine employment. He discussed the fact that Claimant's last coal mine employment as a buggy operator required intermittent but not sustained or continuous heavy labor. At the deposition, Dr. Zaldivar stated Claimant's mild pulmonary impairment is a combination of the coal workers' pneumoconiosis, a bronchospasm and the presence of the mass. Dr. Castle agreed Claimant has some deterioration in his overall ventilatory function since the mass developed; however, his physiologic function remains above disability levels. Dr. Fino agreed Claimant has had a deterioration in lung function from 1997 to 2001, however, he concluded Claimant has no disability due to coal workers' pneumoconiosis. While Dr. Rosenberg concluded Claimant did not have pneumoconiosis, he also concluded the mild restriction and mild obstruction present on testing is minimal and not limiting. Dr. Crisalli concluded, based on the most recent studies performed in March, 2001, that Claimant is totally disabled. He attributed the deterioration in Claimant's pulmonary capacity, however, to the development of the mass which is not related to coal mine employment or coal workers' pneumoconiosis.

Although all the physicians who reviewed the evidence or prepared multiple reports agreed Claimant's respiratory capacity has declined, they disagreed as to whether or not Claimant is now disabled by his pulmonary or respiratory impairment. Drs. Castle, Fino and Rosenberg all concluded that since Claimant's values were above the regulatory values, he is not totally disabled. Dr. Zaldivar was more specific in his finding that Claimant's last coal mine employment required only intermittent heavy labor which he could perform based on the laboratory test results; however, he stated Claimant would be unable to perform continuous heavy labor. Dr. Crisalli concluded Claimant is totally disabled based on the most recent exercise blood gas study results. On consideration of these medical reports, I find the reports of Drs. Zaldivar and Crisalli most complete on the issue of total disability. Rather than merely reviewing the results of the laboratory studies and evaluating whether or not they exceed the regulatory requirements, these two physicians considered the exertion required by coal mine employment. In that respect, Dr. Crisalli concluded the miner was totally disabled since he had shown dropping arterial pO2 values on the most recent exercise blood gas study. Dr. Zaldivar concluded that Claimant would be disabled from continuous heavy labor, but could do intermittent heavy labor. In considering these two opinions, I find Dr. Crisalli's opinion more persuasive. Dr. Crisalli based his finding on the exercise blood gas study results, which most nearly approximate the condition of a

working miner. In addition, Dr. Zaldivar agrees Claimant would be disabled from heavy work. Although Claimant's work as a buggy operator may not routinely have required heavy work, it is also clear from his testimony that shoveling, as well as lifting the cables, was required on a daily basis. Dr. Zaldivar's analysis of the effort required and his conclusion that Claimant could lift the cables occasionally did not consider the work shoveling coal required around the belt line which would be considered additional heavy work. I find, therefore, that Dr. Crisalli's analysis and conclusion regarding Claimant's pulmonary capacity is the most persuasive medical opinion report. Since the other physicians agreed Claimant's pulmonary capacity has declined, I find those opinions do not outweigh Dr. Crisalli's finding that Claimant is totally disabled. Accordingly, I find Claimant has established total disability due to his respiratory or pulmonary condition under the provisions of subsection 718.204(b)(2)(iv). Furthermore, I find Dr. Crisalli's opinion is sufficient to outweigh the contrary evidence of record, specifically the non-qualifying, but declining, pulmonary function study and blood gas study tests.

Since Claimant has now established total disability under one of the methods set forth in subsection 718.204(b), he has established an additional basis for finding a change in condition since the prior denial was based, in part, on the issue of total disability. However, the regulations also require that Claimant establish that such disability is due to pneumoconiosis. 20 C.F.R. 718.204(a).

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a substantially contributing cause of the miner's disability if it: 1) has a material adverse effect on the miner's respiratory or pulmonary condition or; 2) materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

All physicians agreed that the miner's pulmonary condition deteriorated since the mass in his right lung was discovered. The physicians, except for Dr. D'Brot, all agree that the miner's pulmonary decline and subsequent pulmonary disability related to the development of the lung mass is not related to pneumoconiosis or to Claimant's coal mine employment. The miner's treating physician, Dr. D'Brot, concludes that the mass which has developed is due to pneumoconiosis. The other physicians who attribute the development of the mass to the miner's pulmonary decline and who attribute the development of the mass to a malignancy or other conditions not related to coal mine employment or to pneumoconiosis outline two findings in particular which support these conclusions. These physicians note the location of the mass as one basis for finding it is not due to pneumoconiosis since complicated pneumoconiosis usually develops in the upper lobes. This mass, which developed in the mid lobe is not consistent, therefore, with complicated pneumoconiosis. In addition, however, these physicians note the positive PET test which indicates a strong possibility that a malignancy is present. As noted above, neither of the biopsy tests have produced helpful information in evaluating the source of the lung mass. On consideration of these medical opinion reports, I find the opinions of the physicians who conclude the mass is not related to pneumoconiosis most persuasive. Dr. D'Brot's report did not address the location of the mass nor did he discuss the results of the PET test. Thus, his report is outweighed by the contrary conclusions set forth in the reports of Drs. Zaldivar, Fino, Castle, and Crisalli that the

mass is not related to coal workers' pneumoconiosis based on its location and the results of the PET scan. Accordingly, I find Claimant has not established total disability due to pneumoconiosis.

Since I find that Claimant has not established total disability due to pneumoconiosis after consideration of all of the evidence, I find Claimant is not entitled to benefits under the Act. The prior findings in this matter shall be modified to reflect that Claimant has established pneumoconiosis, that such pneumoconiosis arose out of coal mine employment and that he is totally disabled by his pulmonary condition. However, the prior findings shall not be modified to reflect that he has established his total disability is due to pneumoconiosis. Since Claimant has not established that his total disability is due to pneumoconiosis, his claim for benefits shall be denied.

Since the record remains ambiguous about the cause or etiology of the development of the lung mass, if additional tests are obtained within one year of this denial as recommended by various physicians in this matter, including guided needle biopsies or surgical biopsies, and if those tests produce results which attribute the development of the mass to Claimant's pneumoconiosis, the Claimant may again file a request for modification under the provisions of Section 725.310.

Accordingly, Claimant's request for modification is granted on the issue of pneumoconiosis, that such pneumoconiosis arose out of coal mine employment and that Claimant is totally disabled due to a pulmonary or respiratory condition. Claimant's request for modification, however, is not granted on the issue of total disability due to pneumoconiosis. Furthermore, since Claimant has not established total disability due to pneumoconiosis, this claim for benefits shall be denied.

ORDER

Claimant's request for modification of the denial of benefits issued on February 16, 1999 as affirmed by the Benefits Review Board on March 9, 2000, is granted in part and denied in part as set forth above. The claim for benefits remains denied.

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ROBERT J. LESNICK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20018-7601. A copy of this notice must also be served on Donald S. Shire, Associate Solicitor, Room N-2605, 200 Constitution Avenue, N.W., Washington, D.C. 20210.